

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 03/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505525</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/30/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - LACEY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4524 INTELCO LOOP SE LACEY, WA 98503</b>
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**INITIAL COMMENTS**

This report is the result of an unannounced Abbreviated Survey conducted at Manorcare Health Services Lacey on January 30, 2013. A sample of 5 current residents and 3 former residents was selected from a census of 57.

The following complaint(s) were investigated:  
# 2744105

The survey was conducted by:  
[REDACTED], R.N., B.S.N., Investigator

The Complaint Investigator was from:  
Department of Social & Health Services  
Aging & Disability Services Administration  
Residential Care Services,  
District 3, Unit C  
P.O. Box 45819  
Olympia, Washington 98504-5819  
Telephone: 360.664.8420  
Fax: 360.664.8451

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The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.

To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.

3-29-13

RECEIVED  
MAR 28 2013  
DSHS/ADSNHCS

*Inda Ranco* 3-13-13 for IDR Program Manager  
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charon Holmes</i>	TITLE <i>Admin</i>	(X6) DATE <i>3-18-13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p><b>F225</b> It is the practice of this facility to investigate alleged violations and to prevent further potential abuse while the investigation is in process. The results of the investigations are reported to the administrator or designee and to other official's in accordance with state law.</p> <ol style="list-style-type: none"> <li>1. The facility accident and incident log has been updated to include the cited incidents for resident #1,2,3,4,5,6, &amp; 7. The cited incidents were again investigated to rule out abuse and neglect.</li> <li>2. Reviewed similar residents following a fall to ensure the incidents have been accurately logged on facility accident and incident log and that the investigations are complete and thorough and State Hotline notified if appropriate.</li> <li>3. Education will be provided to nursing staff regarding the investigation following a fall to rule out abuse and neglect and timely notification to the administrator and the State Hotline.</li> </ol>	3-29-13 

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record reviews, the facility failed to conduct a thorough investigation of alleged vilotions in accordance with CFR 483.13 (c)(3)(4) for 7 of 43 sampled residents (Resident #1, 2 ,3 ,4, 5, 6 &amp; 7 ) to determine poltential causes, rule out abuse and neglect, and attempt to prevent future falls. In addition, staff failed to report alleged violations to the state Hot line.</p> <p>Findings include:</p> <p>&lt;Resident #1&gt;</p> <p>Resident #1 was admitted to the facility on [REDACTED] 12 with diagnoses to include [REDACTED] and a history of [REDACTED]</p> <p>On 1/22/13 at 10:00 p.m., Resident #1 fell out of his wheelchair and sustained a substantial injury to the head. The resident was transported to a hospital for evaluation and treatment.</p> <p>Although there was an incident report indicating an investigation was conducted, the incident was not logged in the facility accident and incident log of reportable incidents, or reported to the state Hot line.</p> <p>&lt;Resident #2&gt;</p> <p>Resident #2 was admitted to the facility on [REDACTED] 12 with diagnoses to include a history of [REDACTED]</p>	F 225	<p>4. Fall investigations and the facility accident and incident log will be routinely audited by the Administrator to ensure the log is complete and that fall investigations are thorough and that the State Hotline has been notified if abuse and neglect cannot be ruled out. Findings will be brought to the QAA committee for recommendations as appropriate. Administrator or designee to ensure compliance.</p>	<p>3-29-13</p>

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F 225 Continued From page 3  
 [REDACTED] with [REDACTED] (a [REDACTED]) and multiple [REDACTED].

On 1/15/13 an entry into the facility incident and accident log indicated the resident had a fall on 1/13/13 at 7:15 a.m. An entry in the progress notes indicated the resident fell at 5:30 a.m. An LN (Licensed Nurse) documented in the Progress Notes the resident fell and was bleeding profusely from her head, and the paramedics were called.

The accident and incident log of the fall documented time of the incident to have occurred at a different time. Documentation did not support a thorough investigation was conducted to correct inconsistent documentation and to determine if interventions were implemented at the time of the fall to rule out neglect. There was no indication the substantial injury was reported to the state Hotline.

<Resident #3>

Resident #3 was admitted to the facility on [REDACTED] 12 with diagnoses to include [REDACTED] and [REDACTED].

The facility log documented the resident had an incident on 11/19/12 in a bathroom where the resident sustained a substantial injury of a fracture. Documentation did not support a thorough investigation was conducted to determine if care planned interventions were implemented at the time of the fall to rule out neglect. The log documented the state Hotline was not notified of the incident.

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F 225	<p>Continued From page 4</p> <p>&lt;Resident #4&gt;</p> <p>Resident #4 was admitted to the facility on [REDACTED]/12 with diagnoses to include [REDACTED], [REDACTED] and [REDACTED] problems.</p> <p>The facility accident log documented the resident had a fall on 12/2/12 at 6:30 a.m. There was no further documentation as required including the type of injury, findings, facility actions taken or whether the state Hotline was notified.</p> <p>&lt;Resident #5&gt;</p> <p>Resident #5 (former resident) was admitted to the facility on [REDACTED]/12 with diagnoses to include [REDACTED] and [REDACTED]. The resident expired on [REDACTED] 12 in the facility.</p> <p>The facility accident log documented the resident had a fall on 12/12/12 and sustained a substantial injury of a laceration. Documentation did not support a thorough investigation was conducted to determine if interventions were implemented at the time of the incident to rule out neglect. The log documented the state Hotline was not notified of the incident.</p> <p>&lt;Resident #6&gt;</p> <p>Resident #6 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED], [REDACTED], [REDACTED] and [REDACTED].</p>	F 225		

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F 225	Continued From page 5 The facility accident log documented the resident had a 1/7/13 at 4:50 p.m. There was no further documentation as required including the type of injury, findings, facility actions taken or whether the state Hotline was notified.  <Resident #7>  Resident #7 was admitted to the facility on [REDACTED]/12 with diagnoses to include [REDACTED] problems, [REDACTED] problems and [REDACTED].  The facility accident log documented the resident had a fall on 1/5/13 and sustained a substantial injury of a laceration. The log documented the state Hotline was not notified of the incident.  At 6:24 p.m., DNS stated she "knew" better about the log, and knew incidents needed to be logged in 5 days or completed to show an incident was thoroughly investigated but has been "busy."  Refer to F323	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 323	<b>F323</b> The facility strives to ensure residents' environment remains free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.  1. Resident #1 has been discharged. Resident #2 has been reassessed and the care plan updated to ensure planned interventions are in place.	3-29-13 ↓

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F 323	Continued From page 6 by:  Based on observation, interview and record review, the facility failed to provide sufficient supervision or interventions to prevent accidents for 2 of 2 residents (#s 1 & 2) that was consistent with each resident's specific identified conditions, risks, needs or behaviors. These failures to adequately assess or monitor resident responses to planned interventions placed the residents at risk of not having their safety care needs recognized and addressed to prevent future injury.  Findings include:  <Resident #1>  Resident #1 was admitted to the facility on [REDACTED]/12, and then readmitted on [REDACTED]/12 with diagnoses to include [REDACTED], [REDACTED] and a history of [REDACTED].  The resident's Minimum Data Set (MDS), an assessment tool, dated 12/31/12 documented the resident was dependent on staff to provide extensive assist with Activities of Daily Living (ADLs) including safety,, and had fluctuating cognitive abilities. On 1/30/13 at 3:55 p.m., the resident was observed in his room sitting in his wheelchair with his spouse. Resident #1 was unable to provide any additional information regarding his falls in the facility. The spouse stated Resident #1 was more confused at night time.	F 323	2. Similar residents at risk for falls or who have had a fall have been assessed. The care plans have been updated with new interventions as appropriate. 3. The facility will educate staff on assessing patients at risk for falls and after a fall. Review of appropriate interventions and updating of care plans will be included in the education. 4. Resident charts will be routinely audited by nursing management and the Administrator to ensure thorough assessments have been completed and that care plans and interventions are updated and implemented as appropriate. Trends will be reviewed by the QAA committee with recommendations as appropriate. Administrator or designee to ensure compliance.	3-29-13  

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Resident # 1's plan of care, dated 12/20/12, identified the resident had a self care deficit related to impaired mobility and cognition. The resident was identified as being at risk for falls due to impaired balance/impaired coordination, unsteady gait and a history of falls.

The facility goals for the resident were to minimize the risk for falls and "decreasing number of falls." The care planned interventions directed nursing staff to have the resident's bed in the lowest position, to encourage the resident to transfer and change position slowly, have commonly used articles within easy reach.

On 12/22/12, in the evening, the resident had a fall out of his wheelchair while sitting in the hallway.

The Neurological Evaluation Flow Sheet, dated 12/22/12 directs the nursing staff to do a complete neurological evaluation with vital signs initially, then every 30 minutes x 4, then every hour x 4, then every 8 hours x 9 (72) hours. The nursing staff documented/evaluated the resident until 12/23/12 at 0400. There were no further neurological evaluations charted.

On 12/23/12, two new intervention was documented to direct staff to "reinforce need to call for assistance," to have a fall mat in his room, and that Resident #1's spouse was cleared to walk with the resident in his room or the hallway.

On 12/26/12, a witness statement of the fall documented the resident had an advanced dementia and required assistance with all ADL's,

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and had times of increased confusion and was not always able to make his needs known. Although the document indicated increased confusion, the author of the statement documented it was unclear after the investigation why the resident attempted to stand, and was "reasonably related to his [REDACTED]." "Staff need to offer toileting often." The witness statement documented the resident did have "some sleep problems lately as partner states isn't normal for him." The witness statement documented, "Will continue monitor evening patterns and help meet needs."

On 1/22/13 at 10:00 p.m., Resident #1 fell and struck the [REDACTED] of his head. He was transported to an Emergency Department (ED) for evaluation.

On 1/23/13 at 3:43 a.m., the Progress notes documented the resident returned from the ED at 12:15 a.m., and was neurologically "within normal limits (WNL)" and was being monitored by the Registered Nurse (RN).

The next documentation was 18 hours later at 9:42 p.m., where the Licensed Nurse (LN) documented the resident was on alert for a fall with a head injury, the resident's pupils were equal and reactive (a component of a neurological assessment), and that he was being monitored closely due to his [REDACTED] and [REDACTED], as resident had "frequently attempts to get up and walk independently."

On 1/30/13 at 5:00 p.m., LN A was asked what the facility process was when a resident had a fall and struck their [REDACTED]. He stated the resident was

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to have a neurological sheet completed, with neurological checks done as the sheet directed. LN A stated the resident is put on alert charting (nursing charting that is done every shift for 72 hours). LN A stated he did not see there was a neurological sheet done for Resident #1.

The Director of Nursing Services (DNS) was present during the conversation and stated she might have the neurological sheet in her investigative report. At 5:11 p.m., the DNS returned and stated she could not find Resident #1's neurological sheet. She stated "It's a real problem with these electronic charts, because I can't find one, so it doesn't look like one was done since it is not documented."

At 6:23 p.m., the Administrator and DNS stated there is a daily meeting with department staff that discusses issues going on with the residents or new issues that might include falls or a pressure ulcer, but outcomes or ideas are never charted in the resident 's medical record.

<Resident #2>

Resident #2 was admitted to the facility on [REDACTED] 12 with diagnoses to include a history of [REDACTED] with [REDACTED], and [REDACTED].

The Resident's MDS, an assessment tool, dated 12/28/12 documented the resident required an extensive of two persons bed mobility, transfers, toileting, and hygienic care. The resident was documented as having not ambulated while in the facility. The resident was documented as being

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severely cognitively impaired with short and long term memory deficits.

The resident's care plan dated 12/20/12, documented the resident was identified as "at risk for falls due to unsteady [REDACTED], [REDACTED], potential [REDACTED] side effects," and the goal was for Resident #2 to "minimize risk for injury r/t (related to) falls" and "decreasing number of falls." The care planned interventions directed staff to "encourage to transfer and change positions slowly, have commonly used articles within easy reach." On 1/8/13, a revision was made to the care plan that documented nursing to "provide assist to transfer and ambulate as needed-patient is a two person maxi lift ( a mechanical lift used to transfer resident)."

On 1/12/13 the Progress notes documented the resident was found at 4:30 p.m., on the floor lying next to her bed. It documented the resident did not have any visible signs of injury, was awake. It was documented resident's needs "are anticipated by the nursing staff. She is not able to make her needs known."

On 1/13/13 at 5:41 a.m., the Progress Notes documented "Pt (patient) on alert for previous fall. Pt. had no c/o (complaints of pain or discomfort this NOC (night) shift. Slept most of NOC shift. WCTM (will continue to monitor)."

At 7:27 a.m., the Progress notes documented "Pt found on floor of room this a.m. at 0530 (5:30 a.m.) pt was conscious, [REDACTED] from upper [REDACTED] eye laceration. Pt is severely demented and unable to communicate effectively." The Progress Note documented the residents vital

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F 323	<p>Continued From page 11</p> <p>signs, the paramedics were called, and the resident was put on alert (an alert to nursing staff to document the resident's status) when she returned to facility. The Progress Note documented. The "Pt was already on alert for previous non-injury fall, will follow up with fall precaution and care plan update."</p> <p>On 1/14/13, a statement authored by a LN regarding the injury fall documented "Two Aids-both left the scene, primary is Z, found pt. Incident occurred rt (right) before shift change &amp; (and) did not go smoothly. Pt with laceration (a cut) above [redacted] brow, conscious, alert, not oriented (normal) unable to express self (normal) other than to cry out when moved. Paramedics transported pt to hospital received [redacted] back in facility."</p> <p>On 1/30/13 at 5:40 p.m., the resident was observed in her wheelchair in front of the nurses' station with a family member. She was awake, and looked at the investigator when her name was spoken. She began slapping her hand on her wheelchair arm rest as the investigator asked how she was doing. She stated she was not in pain, then immediately stated she was, and changed her answer several times. The family member stated she can't always say what she wants or how she is doing.</p> <p>At 5:42 p.m., LN B stated the resident is very confused and becomes agitated easily with too much stimulus. She stated the resident has routine pain medication to attempt to manage her pain since she isn't cognitively able to do so consistently. In reviewing her care plans, LN B stated the care plans are generic and are used</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

IDR AMENDED

PRINTED: 03/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505525</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/30/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MANORCARE HEALTH SERVICES - LACEY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4524 INTELCO LOOP SE LACEY, WA 98503</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Continued From page 12

for all of the residents. Resident #2's needs were met by LN B because she has been a nurse for a long time and knew what non-verbal signs to watch for in Resident #2. LN B stated Resident #2 does best with low stimuli and a consistent routine, and she believes this reduces any chance of falls, although the supervisor hasn't care planned this information to direct other staff to provide the same interventions.

At 6:24 p.m., ADM and DNS stated each day they discuss what is going on different residents and that might include falls or skin issues in their meetings, but it is never documented. DNS stated she "knew" better about the log, and knew it needed to be logged in 5 days or completed to show an incident was thoroughly investigated but has been " busy ".

There was no further evidence in the chart that the care plans were changed to reflect each resident's needs based on their limited cognition, identified risks, current status, responses to generic interventions or newly revised interventions for staff tp provide to attempt to prevent other injury falls.

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